FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012328

Facility Name: Apostolic Christian Home of Eureka

Address: 610 West Cruger (Number) Eureka (City) 61530 (Zip Code)

County: Woodford

Telephone Number: (309) 467-2311 **Fax #** (309) 467-2584

IDPA ID Number: 37-6036029001

Date of Initial License for Current Owners: 16-Feb-66

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Thomas A. Hoffman **Telephone Number:** (309) 467-2311

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Thomas A. Hoffman
(Title) Administrator

Paid Preparer

(Signed) March 11, 2003 (Date)
(Print Name and Title) Robert Rein, Practitioner
(Firm Name & Address) Robert Rein, CPA, P.O. Box 201, Morton, Illinois 61550-0201
(Telephone) (309) 266-8178 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	71	Skilled (SNF)	71	25,915	1
2		Skilled Pediatric (SNF/PED)			2
3	38	Intermediate (ICF)	38	13,870	3
4		Intermediate/DD			4
5	10	Sheltered Care (SC)	10	3,650	5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,768	14,413	843	24,024	8
9	SNF/PED					9
10	ICF	2,069	11,137		13,206	10
11	ICF/DD					11
12	SC		3,013		3,013	12
13	DD 16 OR LESS					13
14	TOTALS	10,837	28,563	843	40,243	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.65%

D. How many bed-hold days during this year were paid by Public Aid? 37 **(Do not include bed-hold days in Section B.)**

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Apartment, Duplex, Condominium

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 16-Feb-66

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] **Date** 16-Feb-66 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] **If YES, enter number of beds certified** 8 **and days of care provided** 843

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 **Fiscal Year:** 12/31/2002

*** All facilities other than governmental must report on the accrual basis.**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	263,316	22,267	15,201	300,784		300,784		300,784			1
2	Food Purchase		218,886		218,886		218,886	(9,152)	209,734			2
3	Housekeeping	109,962	17,964	640	128,566		128,566	(4,659)	123,907			3
4	Laundry	129,052	15,323	2,382	146,757		146,757		146,757			4
5	Heat and Other Utilities			155,574	155,574		155,574	(27,492)	128,082			5
6	Maintenance	140,352	17,955	33,071	191,378		191,378	(29,150)	162,228			6
7	Other (specify):*											7
8	**TOTAL General Services**	642,682	292,395	206,868	1,141,945		1,141,945	(70,453)	1,071,492			8
	B. Health Care and Programs											
9	Medical Director			1,500	1,500		1,500		1,500			9
10	Nursing and Medical Records	1,990,175	21,494	38,791	2,050,460	39,757	2,090,217		2,090,217			10
10a	Therapy	67,835	1,397	48,010	117,242		117,242	(490)	116,752			10a
11	Activities	129,978	7,317	5,929	143,224		143,224	(864)	142,360			11
12	Social Services	44,713	265	2,597	47,575		47,575		47,575			12
13	Nurse Aide Training					14,838	14,838	(5,433)	9,405			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,232,701	30,473	96,827	2,360,001	54,595	2,414,596	(6,787)	2,407,809			16
	C. General Administration											
17	Administrative	136,740			136,740		136,740	(17,900)	118,840			17
18	Directors Fees											18
19	Professional Services			6,242	6,242		6,242		6,242			19
20	Dues, Fees, Subscriptions & Promotions			12,231	12,231	2,390	14,621		14,621			20
21	Clerical & General Office Expenses	81,922	6,319	50,156	138,397	(2,230)	136,167	(10,997)	125,170			21
22	Employee Benefits & Payroll Taxes			615,132	615,132	(160)	614,972	(5,465)	609,507			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,660	11,660	(2,412)	9,248	(482)	8,766			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			91,126	91,126		91,126	(22,544)	68,582			26
27	Other (specify):*											27
28	**TOTAL General Administration**	218,662	6,319	786,547	1,011,528	(2,412)	1,009,116	(57,388)	951,728			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,094,045	329,187	1,090,242	4,513,474	52,183	4,565,657	(134,628)	4,431,028			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Apostolic Christian Home of Eureka 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	**Salary/Wage 1**	**Supplies 2**	**Other 3**	**Total 4**	**5**	**6**	**7**	**8**	**9**	**10**	
30	Depreciation			298,060	298,060		298,060	(111,488)	186,572			**30**
31	Amortization of Pre-Op. & Org.											**31**
32	Interest											**32**
33	Real Estate Taxes			4,386	4,386		4,386	(4,386)	(0)			**33**
34	Rent-Facility & Grounds											**34**
35	Rent-Equipment & Vehicles											**35**
36	Other (specify):*											**36**
37	**TOTAL Ownership**			302,446	302,446		302,446	(115,874)	186,572			**37**
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											**38**
39	Ancillary Service Centers		106,093	2,831	108,924	(52,183)	56,741	93	56,834			**39**
40	Barber and Beauty Shops			23,064	23,064		23,064		23,064			**40**
41	Coffee and Gift Shops											**41**
42	Provider Participation Fee			59,677	59,677		59,677		59,677			**42**
43	Other (specify):*											**43**
44	**TOTAL Special Cost Centers**		106,093	85,572	191,665	(52,183)	139,482	93	139,575			**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,094,045	435,280	1,478,260	5,007,585		5,007,585	(250,409)	4,757,176			**45**

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 2/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,152)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(81)	21.3		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(35,937)	30.3		9
10	Interest and Other Investment Income		32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional		21.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	(5,433)	13.3		27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	(199,806)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (250,409)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (250,409)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Facility Name & ID Number Apostolic Christian Home of Eureka **#** 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	**Ownership %**	**Name**	**City**	**Name**	**City**	**Type of Business**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] **YES** [X] **NO**

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

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13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. **Square Feet:** 42,865 **B. General Construction Type:** **Exterior** Brick **Frame** Protected Ord. & Fire Res **Number of Stories** One

C. **Does the Operating Entity?** [X] **(a) Own the Facility** [ ] **(b) Rent from a Related Organization.** [ ] **(c) Rent from Completely Unrelated Organization.**

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. **Does the Operating Entity?** [X] **(a) Own the Equipment** [ ] **(b) Rent equipment from a Related Organization.** [ ] **(c) Rent equipment from Completely Unrelated Organization.**

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. **List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).**

F. **Does this cost report reflect any organization or pre-operating costs which are being amortized?** [ ] **YES** [X] **NO**
If so, please complete the following:

1. Total Amount Incurred: **2. Number of Years Over Which it is Being Amortized:**

3. Current Period Amortization: **4. Dates Incurred:**

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	63,500	1963	$ 58,945	1
2					2
3	TOTALS	63,500		$ 58,945	3

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Home of Eureka COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0012328

CONTACT PERSON REGARDING THIS REPORT Thomas A. Hoffman

TELEPHONE (309) 467-2311 FAX #: (309) 467-2584

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		05/19/05	12/31/66	$ 488,404	$ 12,210	40	$ 12,210	$	$ 451,791	4
5	38		05/28/05	12/31/75	605,234	15,091	40	15,131	40	402,069	5
6			06/16/05	08/25/94	1,522,126	38,053	39	39,029	976	325,919	6
7			06/16/05	12/27/94	226,582	6,237	39	5,810	(427)	46,570	7
8				02/13/89	3,512	176	20	176		2,376	8
	Improvement Type**										
9				12/31/67	17,605	440	40	440		15,816	9
10				12/31/68	1,508		20			1,508	10
11				12/31/69	11,406		20			11,406	11
12				12/31/70	8,431		20			8,431	12
13				12/31/71	2,975		20			2,975	13
14				12/31/72	550		5			550	14
15				12/31/77	38,346		20			38,346	15
16				12/31/79	1,260		5			1,260	16
17				12/31/81	4,140		10			4,140	17
18				12/31/82	15,776	770	20		(770)	15,776	18
19				12/31/83	4,826		10			4,826	19
20				12/31/84	8,271		10			8,271	20
21				12/31/85	15,630		20	782	782	14,076	21
22				12/31/86	8,500		10			8,500	22
23				12/31/87	950		19	50	50	800	23
24				12/31/88	69,201	3,460	20	3,460		51,900	24
25	Kitchen Addition			12/31/89	12,677	634	20	634		8,559	25
26	Bldg Improvement			12/31/89	10,281		10			10,281	26
27	Water Heater			12/31/90	2,272		20	114	114	1,463	27
28	Central Air			12/31/90	3,978		10			3,978	28
29	Improve Door			12/31/90	2,235		10			2,235	29
30	Remodeling			12/31/90	503	25	20	25		313	30
31	Sprinkler Heads			12/31/90	1,504	75	20	75		950	31
32	Blacktopping			12/31/90	3,000	150	20	150		1,925	32
33	Cubicle Curtain Track			01/21/91	850	43	20	43		513	33
34	Carpeting/Woodwork			01/31/91	795	40	20	40		476	34
35	Key Pads/Door System			03/31/91	2,670	134	20	134		1,575	35
36	Thermo Mixing Valves			04/15/91	3,310	166	20	166		1,944	36

***Total beds on this schedule must agree with page 2.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

See Page 12A, Line 70 for total

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air Conditioning Unit	06/25/91	$ 3,012	$	10	$	$	$ 3,012	37
38	Wall Air Conditioning Unit	08/06/91	910		10			910	38
39	Patio	06/01/91	2,150	108	20	108		1,251	39
40	Asphalt Parking	05/29/92	8,938	447	20	447		4,734	40
41	Trees & Shrubs	05/19/92	403	20	20	20		212	41
42	Radiator Covers	01/10/92	5,500	275	20	275		3,018	42
43	Plumbing Upgrade	01/15/92	2,348	117	20	117		1,283	43
44	Shed	06/08/92	2,000	100	20	100		1,056	44
45	Alarm System	06/30/92	4,520	226	20	226		2,374	45
46	Lock Sets	11/30/92	1,207	60	20	60		605	46
47	Water Heater	03/15/92	10,252	513	10	210	(303)	10,252	47
48	Air Conditioner	06/16/92	886	44	10	37	(7)	886	48
49	Air Conditioner	07/09/92	926	46	10	45	(1)	926	49
50	Air Conditioner	09/30/92	858	43	10	62	19	858	50
51	Drapes and Rods	11/30/92	1,057	53	10	94	41	1,057	51
52	Fireplace Glass	11/30/92	587	29	10	51	22	587	52
53	Air Conditioner	05/14/93	1,303	130	10	130		1,252	53
54	Fountain Lights	09/20/93	1,179	118	10	118		1,095	54
55	Exterior Lighting	03/15/93	850	42	20	43	1	421	55
56	Hallway Remodeling	04/21/93	2,383	119	20	119		1,154	56
57	Kitchen Flooring	06/15/93	2,441	122	20	122		1,165	57
58	Office Addition	05/01/94	57,234	1,431	39	1,468	37	12,725	58
59	Roof	10/01/94	17,577	879	20	879		7,251	59
60	Interior Hallway	06/30/94	7,134	713	10	713		6,064	60
61					-				61
62	Phone System	06/30/94	13,120	1,312	10	1,312		11,157	62
63	Air Conditioner	05/15/95	1,158	116	10	116		885	63
64	Drapes	12/15/95	529	53	10	53		373	64
65	Remodel	02/15/95	5,366		5			5,366	65
66	Improvements	04/15/95	3,293	329	10	329		2,538	66
67	Roof & Insulation	06/30/95	21,002	1,050	20	1,050		7,879	67
68	Building Improvements	10/15/95	7,787	779	10	779		5,617	68
69	Life Safety Code	12/15/95	21,125	1,056	20	1,056		7,438	69
70	**TOTAL (lines 4 thru 69)**		$ 3,308,343	$ 88,034		$ 88,608	$ 574	$ 1,556,919	70

****Improvement type must be detailed in order for the cost report to be considered complete.**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,308,343	$ 88,034		$ 88,608	$ 574	$ 1,556,919	1
2	Air Conditioner	02/15/96	485	49	10	49		337	2
3	Phone System-Social Service	02/15/96	1,201	120	10	120		825	3
4	Air Conditioner	05/31/96	2,886	289	10	289		1,903	4
5	Water Softner	06/15/96	3,442	344	10	344		2,252	5
6	Social Service Office Remodel	01/15/96	2,750	207	20	138	(69)	1,303	6
7	Life Safety Code	02/15/96	8,113	336	20	406	70	2,451	7
8	Life Safety Door	03/15/96	5,061	253	20	253		1,720	8
9	Front Room Wallpaper	05/01/96	1,008	101	10	101		673	9
10	Ventilation & A/C System	05/30/96	5,990	599	10	599		3,947	10
11	Front Room Carpet	05/31/96	2,432	122	20	122		803	11
12	Guttering System	06/15/96	3,355	168	20	168		1,099	12
13	Air Conditioning	06/15/96	9,314	466	20	466		3,050	13
14	Air Conditioning	08/15/96	1,008	50	20	50		319	14
15	Cabinetry in Tub Room	09/15/96	2,945	295	10	295		1,856	15
16	Air Conditioning & Ventilation System	09/15/96	8,942	447	20	447		2,813	16
17	Speaker System	10/15/96	3,798	380	10	380		2,360	17
18	Life Safety Ventilation System	10/15/96	798	40	20	40		248	18
19	Six Air Conditioners	02/28/97	2,882	288	10	288		1,682	19
20	Water Heater	05/31/97	5,871	587	10	587		3,279	20
21	Wall Fountain	10/28/97	653	65	10	65		336	21
22	Draperys	10/31/97	2,839	284	10	284		1,467	22
23	Smoke Detectors	01/31/97	3,103	310	10	310		1,834	23
24	Carpeting	10/31/97	3,525	176	20	176		909	24
25	Hall Remodeling	10/31/97	16,641	832	20	832		4,299	25
26	Five Air Conditioners	03/20/98	2,447	245	10	245		1,172	26
27	Water Heater	10/12/98	2,940	294	10	294		1,240	27
28	Air Conditioner	11/30/98	5,415	542	10	542		2,214	28
29	Room Door Guards	03/16/99	2,139	214	10	214		812	29
30	Door Alarm Keypads	07/14/99	2,293	229	10	229		794	30
31	Seven Air Conditioners	01/31/99	3,182	318	10	318		1,245	31
32	Kitchen Shelving Units	05/25/99	2,838	283	10	284	1	1,023	32
33	Three Air Conditioners	08/18/99	1,425	143	10	143		482	33
34	**TOTAL (lines 1 thru 33)**		$ 3,430,064	$ 97,110		$ 97,686	$ 576	$ 1,607,666	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,430,064	$ 97,110		$ 97,686	$ 576	$ 1,607,666	1
2	Room Door Guards	12/13/99	2,610	261	10	261		796	2
3	Seven Air Conditioners	01/31/00	3,626	363	10	363		1,059	3
4	Air Conditioner	09/15/00	1,508	151	10	151		346	4
5	Generator & Building	01/31/00	303,143	7,579	40	7,579		22,114	5
6	Wall Carpet	01/01/00	3,630	363	10	363		1,089	6
7	Carpeting	03/31/00	21,956	2,196	10	2,196		6,046	7
8	Courtyard Improvements	05/31/00	5,312	261	10	531	270	1,062	8
9	Courtyard Improvements	05/31/99	11,738	1,444	10	1,174	(270)	3,374	9
10	Air Conditioner	05/15/01	632	63	10	63		103	10
11	Lighting	07/15/01	2,233	447	5	447		654	11
12	Attached Wash Stations	08/15/01	849	85	10	85		117	12
13	Hot Water Heater	10/15/01	939	188	5	188		228	13
14	Counter Top	12/01/01	550	55	10	55		60	14
15	Air Conditioner	08/01/01	9,725	486	20	486		688	15
16	Installation of Sinks	09/15/01	1,050	105	10	105		136	16
17	New Dumpster Door	03/31/02	928	23	20	35	35	35	17
18	Flooring for 2002 addition and remodel	12/31/02	85,333	2,133	20				18
19	2002 addition and remodel	12/31/02	2,247,842	28,098	40				19
20	Room designation	02/15/02	627	31	10	55	55	55	20
21	Water heater	02/28/02	4,147	207	10	348	348	348	21
22	Drapes and blinds for dining, activity, therapy	12/31/02	15,437	772	10				22
23	Courtyard sprinkler system	06/01/02	8,800	440	10	514	514	514	23
24	Gravel driveway	06/01/02	634	63	5	74	74	74	24
25	Landscaping for 2002 addition	12/31/02	198,700	4,967	20				25
26	Sprinkler system for 2002 addition	12/31/02	9,600	480	10				26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		$ 6,371,613	$ 148,371		$ 112,759	$ 1,602	$ 1,646,564	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 572,478	$ 60,380	$ 60,380	$	10	$ 321,179	71
72	Current Year Purchases	105,759	5,583	5,583		10	5,583	72
73	Fully Depreciated Assets	529,753					529,753	73
74								74
75	TOTALS	$ 1,207,990	$ 65,963	$ 65,963	$		$ 856,515	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	91 Chevy Van	05/04/92	$ 24,464	$ 1,223	$ 1,227	$ 4	10	$ 24,464	76
77	Maintenance	86 Chevy Pickup	05/24/96	8,159	1,145	816	(329)	10	3,875	77
78	Maintenance	98 Dodge Truck	02/03/99	13,280	1,328	1,328		10	5,188	78
79	Patient Transport	99 Ford Chassis	06/02/99	49,239	4,924	4,924		10	17,632	79
80	TOTALS			$ 95,142	$ 8,620	$ 8,295	$ (325)		$ 51,159	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,733,690	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 222,954	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 187,017	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (35,937)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,554,238	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments	$ 367,948	$ 11,912	$ 314,660	86
87	Condos	1,362,517	34,888	448,489	87
88	Duplexes	859,910	28,306	569,408	88
89	Rental Units	202,042			89
90	Land	236,950			90
91	TOTALS	$ 3,029,367	$ 75,106	$ 1,332,557	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Process	$	92
93			93
94			94
95		$	95

* **Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.**

** **This must agree with Schedule V line 30, column 8.**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO **Terms:** *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ **Description:**
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [x]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [x]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		5,740		5,740
4	Clinical Wages (b)		2,870		2,870
5	In-House Trainer Wages (c)		230		230
6	Transportation				
7	Contractual Payments			5,283	5,283
8	Nurse Aide Competency Tests		565	150	715
9	TOTALS	$	$ 9,405	$ 5,433	$ 14,838
10	SUM OF line 9, col. 1 and 2 (e)	$ 9,405			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 1,740

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	3
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	13

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	163	$ 10,187	$	163	$ 10,187	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		41	2,788		41	2,788	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		35	1,625		35	1,625	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				31,570		31,570	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical Supplies	39.2					22,434		22,434	13
14	TOTAL			$	239	$ 14,600	$ 54,004	239	$ 68,603	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 592,149	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	309,179		3
4	Supply Inventory (priced at FIFO)	37,065		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,163		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 943,556	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	502,529		13
14	Buildings, at Historical Cost	8,645,599		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,568,743		16
17	Accumulated Depreciation (book methods)	(3,928,674)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Process			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,788,197	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,731,753	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (197,767)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(176,617)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(33,072)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(1,154)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	(46,163)		36
37	Life Lease Deferred Income	(202,963)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (657,736)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Life Lease Equity	(1,807,191)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,807,191)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,464,927)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,266,826)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (7,731,753)	$	48

***(See instructions.)**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	**$** 5,148,622	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,148,622	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	118,204	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 118,204	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,266,826	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ (4,542,579)	1
2	Discounts and Allowances for all Levels	387,991	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (4,154,588)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(94,354)	6
7	Oxygen	(20,790)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ (115,144)	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(23,044)	13
14	Non-Patient Meals	(9,152)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(43,587)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(6,583)	19
20	Radiology and X-Ray		20
21	Other Medical Services	(139,244)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (221,610)	23
	D. Non-Operating Revenue		
24	Contributions	(349,934)	24
25	Interest and Other Investment Income***	(45,968)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (395,902)	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	(5,128)	28
28a	Non-Care Facility	(233,417)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (238,545)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ (5,125,789)	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,141,945	31
32	Health Care	2,360,001	32
33	General Administration	1,011,528	33
	B. Capital Expense		
34	Ownership	302,446	34
	C. Ancillary Expense		
35	Special Cost Centers	131,988	35
36	Provider Participation Fee	59,677	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,007,585	40
41	**Income before Income Taxes (line 30 minus line 40)****	(118,204)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (118,204)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 59,301	$ 28.51	1
2	Assistant Director of Nursing	2,080	2,080	44,884	21.58	2
3	Registered Nurses	24,346	26,783	577,067	21.55	3
4	Licensed Practical Nurses	14,506	16,132	262,700	16.28	4
5	Nurse Aides & Orderlies	83,800	92,371	1,037,764	11.23	5
6	Nurse Aide Trainees	1,230	1,230	8,239	6.70	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,568	4,995	67,835	13.58	8
9	Activity Director	1,331	1,532	19,117	12.48	9
10	Activity Assistants	12,046	13,413	110,861	8.27	10
11	Social Service Workers	3,920	3,962	44,713	11.29	11
12	Dietician					12
13	Food Service Supervisor	2,088	2,088	28,394	13.60	13
14	Head Cook	3,872	4,190	38,829	9.27	14
15	Cook Helpers/Assistants	7,127	7,613	63,387	8.33	15
16	Dishwashers	16,293	17,766	132,706	7.47	16
17	Maintenance Workers	6,549	7,147	121,507	17.00	17
18	Housekeepers	12,248	13,692	105,824	7.73	18
19	Laundry	13,606	15,041	129,052	8.58	19
20	Administrator	1,808	1,808	72,413	40.05	20
21	Assistant Administrator					21
22	Other Administrative	6,461	7,158	54,862	7.66	22
23	Office Manager	1,808	1,808	46,427	25.68	23
24	Clerical	1,527	1,808	15,230	8.42	24
25	Vocational Instruction	13	13	220	16.92	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	223,307	244,710	$ 3,041,332 *	$ 12.43	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	171	$ 7,298	1.3	35
36	Medical Director	12	1,500	9.3	36
37	Medical Records Consultant	7	1,160	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	29	3,120	10.3	39
40	Physical Therapy Consultant	160	8,000	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,472	11.3	44
45	Social Service Consultant	48	2,472	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	475	$ 26,021		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 592	10.3	50
51	Licensed Practical Nurses	82	2,892	10.3	51
52	Nurse Aides	732	12,854	10.3	52
53	TOTAL (lines 50 - 52)	830	$ 16,338		53

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas A. Hoffman	Administrator	-0-	$ 83,320
Kim Joos	Business Manager	-0-	53,420
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,740

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heinald Banwart	Accounting	$ 950
First American Title	Title Service	37
Robert Rein, CPA	Consulting	5,201
Woodford County Recorder	Deed Service	54
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 6,242

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,510
Unemployment Compensation Insurance	7,453
FICA Taxes	225,476
Employee Health Insurance	278,929
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Hepatitis Immunization	1,068
Employee Life/Disability	4,531
Employee Physicals	1,024
Uniform Allowance	(22)
Tax Deferred Annuity	47,442
Non-Care Employee Benefits	(9,904)
TOTAL (agree to Schedule V, line 22, col.8)	$ 609,507

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,703
Health Care Worker Background Check	264
(Indicate # of checks performed 22 **)**	
Life Services Network Dues	6,583
Wellspring Innovative Solutions	2,878
Journal Star & Pantagraph Newspaper	403
Nursing Manuals & Soc Serv Books	805
Other Membership Dues \ Licenses	985
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,621

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ (482)
In-State Travel	428
Seminar Expense	8,820
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,766

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Apostolic Christian Home of Eureka # 0012328 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network Dues 6,583

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8.5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 52,089 Line 10.2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 59,677
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Yes Indicate the amount. $ 9,152

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N\A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.